VIRGINIA DEPARTMENT OF HEALTH

Office of Licensure and Certification

Division of Certificate of Public Need

Staff Analysis

June 20, 2023

COPN Request No. VA-8697
Johnston Memorial Hospital, Inc.
Abingdon, Virginia
Introduce Child/Adolescent Psychiatric Services
with 16 Inpatient Psychiatric Beds

Applicant

Johnston Memorial Hospital, Inc. (JMH) is a nonstock Virginia corporation formed in 1917. In 2009, JMH became a part of Mountain States Health Alliance (MSHA) which held 50.1% membership interest. Johnston Memorial Healthcare Foundation held the remaining 49.9% membership interest in the corporation. JMH moved to its current location in 2011, and in 2021, Ballad Health assumed full ownership of JMH. It is a 116-bed acute care hospital providing a variety of healthcare services including acute inpatient care, diagnostic services, inpatient and outpatient surgery cardiac catheterization and cancer treatment. JMH is located in Abingdon, Virginia in Health Planning Region (HPR) III, Planning District (PD) 3.

Background

According to 2021 Virginia Health Information (VHI) data, the most recent year for which such data are available, and Division of Certificate of Public Need (DCOPN) records, there are currently two providers of inpatient psychiatric services in PD 3 with a total of 48 licensed inpatient psychiatric beds. In 2021, 32 of the 48 licensed beds were staffed, 66.7% (**Table 1**). Furthermore, VHI data for 2021 indicate that licensed psychiatric beds in PD 3 were 43.0% occupied (**Table 2**). DCOPN notes that there are no providers in PD 3 that offer child and/or adolescent psychiatric services.

Table 1. Licensed and Staffed Inpatient Psychiatric Beds in PD 3

Facility Name	Facility Type	Bed Classification	Licensed Beds	Staffed Beds	% of Licensed Beds Staffed
Ridgeview Pavilion (Bristol Region)	Psychiatric Hospital	Psych Bed - Psych Adult	28	20	71.4%
Twin County Regional Hospital	Acute Hospital	Psych Bed - Other Adult	20	12	60.0%
PD 3			**48**	**32**	**66.7%**

Source: VHI Data (2021) & DCOPN Records

Table 2. PD 3 Psychiatric Bed Utilization in 2021

Facility Name	Licensed Beds	Staffed Beds	Licensed Bed Available Days	Staffed Bed Available Days	Patient Days	Occupancy Rate per Licensed Bed
Ridgeview Pavilion (Bristol Region)	28	20	10,220	7,300	5,753	56.3%
Twin County Regional Hospital	20	12	7,300	4,380	1,786	24.5%
PD 3 Totals/Averages	**48**	**32**	**17,520**	**11,680**	**7,539**	**43.0%**

Source: VHI Data (2021)

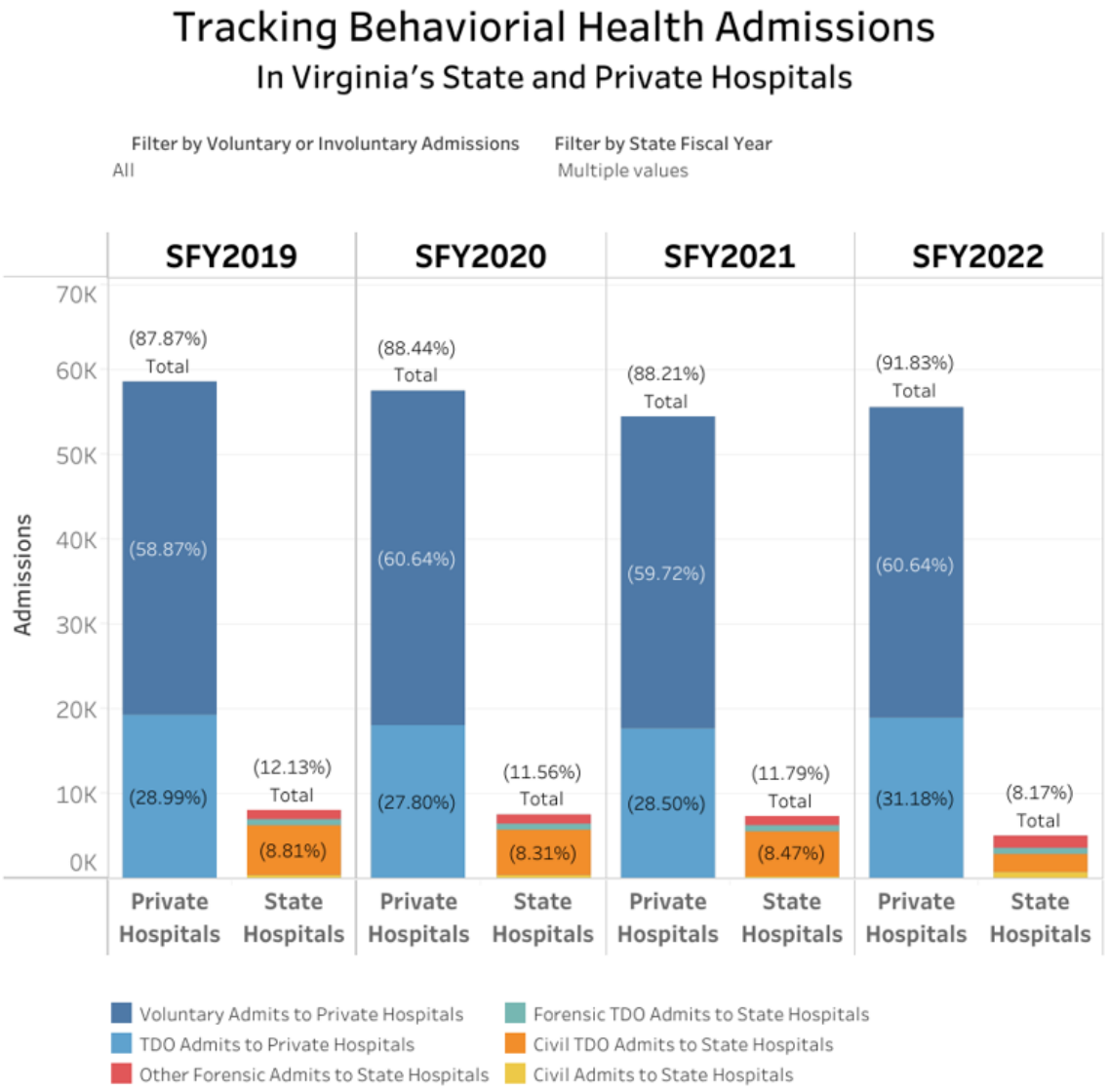
It is important to note that VHI data do not include state psychiatric facilities; however, the Virginia Hospital and Healthcare Association has created a Virginia Behavioral Health Inpatient Data Dashboard[1] that combines data from both Virginia's state psychiatric hospitals and private hospitals offering psychiatric and substance abuse services across the Commonwealth; These data are helpful in providing a more complete picture of patients that are able to access inpatient care in Virginia. **Figure 1** shows the breakdown of psychiatric and substance abuse patient admissions in Virginia who are admitted voluntarily versus those who are admitted involuntarily, for example, on temporary detention orders (TDO). Focusing on state fiscal year 2021, the most recent year with complete information, **Figure 1** indicates private facilities admitted 88.2% of psychiatric inpatients and state facilities admitted 11.8%. **Figure 2** shows only involuntary admissions and indicates that 74.8% of these were admitted to private hospitals and 25.2% to state hospitals.

Patients admitted on TDOs have mental illnesses and it has been determined that they are likely to cause harm to themselves or to others, or that their mental illness impairs their ability to protect themselves or to meet their basic needs. These patients tend to be more violent and problematic than those seeking care voluntarily. In 2014, the Virginia General Assembly passed the "bed of last resort" law that mandates that state mental health hospitals accept patients under a TDO if no bed can be found in a private psychiatric facility within eight hours of the order.

Figure 3 shows the number of patients under TDO admitted to state mental health hospitals increased from 2,623 in FY15 to 6,649 in 2019 (153%). The decline in TDO admissions to state hospitals in 2020 and 2021 is not due to decreasing demand, but to a system unable to accept additional admissions, despite increasing need through the COVID pandemic and its aftermath. In 2021, the commissioner of the Virginia Department of Behavioral Health and Developmental Services (DBHDS) closed five of the state's nine hospitals to additional admissions, citing "severe understaffing and high census levels that created "unprecedented levels of danger."[2]

[1]Virginia Hospital & Healthcare Association Virginia's *Behavioral Health Inpatient Data Dashboard* at: https://www.vhha.com/advocacy/virginia-behavioral-health-inpatient-data-dashboard/
[2]Masters, Kate, *Amid a crisis at state mental hospitals, calls for private providers to step up*, Virginia Mercury, July 20, 2021 at: https://www.virginiamercury.com/2021/07/20/amid-a-crisis-at-state-mental-hospitals-calls-for-private-providers-to-step-up/

Figure 1



Data Source: Department of Behavioral Health and Developmental Services (DBHDS); VHHA Inpatient Database. Voluntary BH Admits to Private Hospitals determined by subtracting the DBHDS private TDO admissions from private hospital admissions in MDC19 with a psych bed revenue code; Substance abuse admits defined using MDC20 and MDC21 and a psych bed revenue code; SFY 2020, SFY 2021, and SFY 2022 volumes were impacted significantly due to the COVID-19 pandemic; SFY 2022 volumes only reflect a partial based on the availability of DBHDS & VHHA data; Psychiatric bed revenue codes are defined with codes: 114, 124, 134, 144, 154, and 204.

VHHA Data Analytics | Updated October 2022

According to the Governor of Virginia official website in December 2022,[3] "Individuals under TDOs are often in crisis and unable to receive care due to lack of appropriate resources and barriers in the TDO process. The average wait time for an individual under TDO to receive a placement and care has risen to 43 hours in Virginia." He announced the launch of the Prompt

[3]*Governor Glenn Youngkin Launches Prompt Placement Taskforce*, Governor of Virginia: An official website of the Commonwealth of Virginia,: https://www.governor.virginia.gov/newsroom/news-releases/2022/december/name-946397-en.html

Placement TDO Task Force which includes government agencies, public and private hospitals, law enforcement, and other community partners to address the crisis facing people with TDOs who are waiting for behavioral health services.

The scope of this analysis does not include state hospitals, but information on that mental health sector is provided for context.

Figure 2

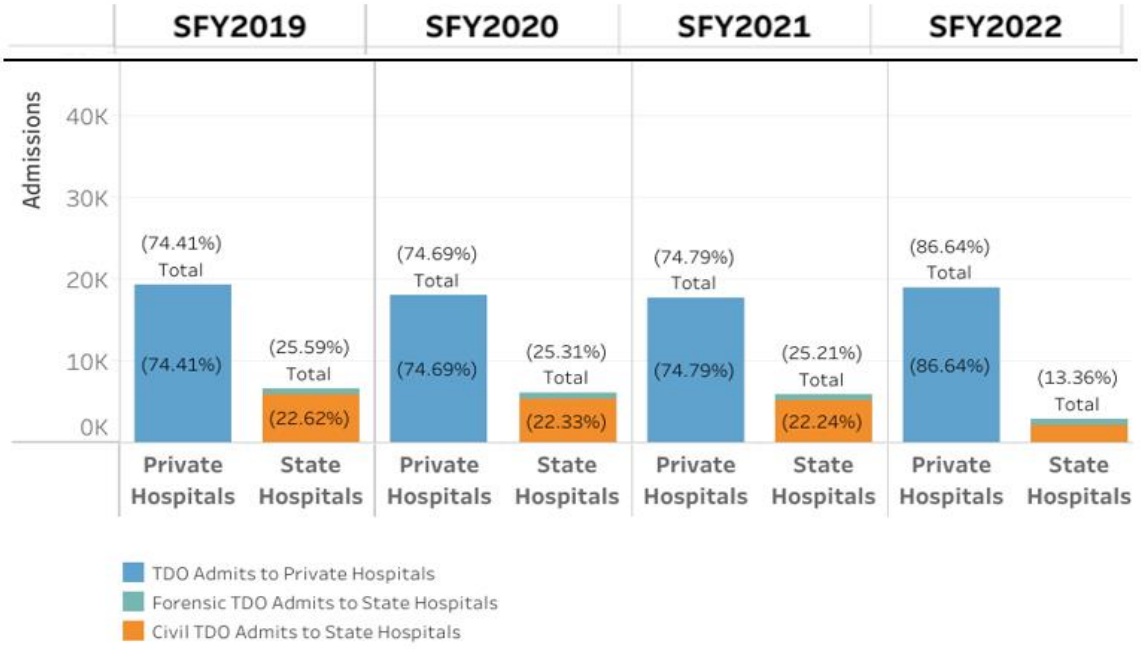
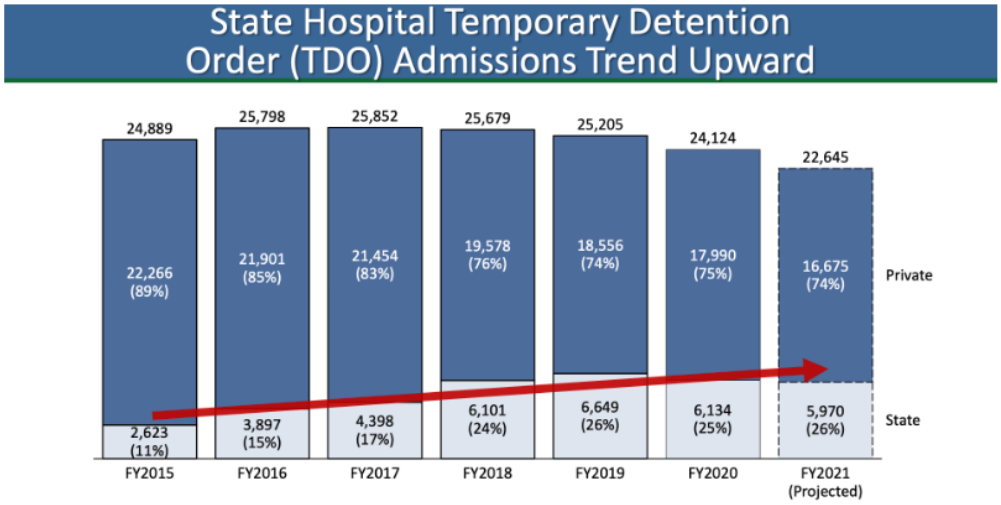


Figure 3



Data from the Virginia Department of Behavioral Health and Developmental Services show that private hospitals have been accepting a declining share of involuntary psychiatric admissions. (Courtesy of DBHDS)

Proposed Project

JMH proposes to introduce inpatient child and adolescent psychiatric services (defined as ranging in age from six to seventeen) through the addition of 16 psychiatric beds. Approval of the project would result in JMH having 132 beds in total. The proposed project would be located on the 4th floor of the South Wing of JMH in 11,676 square feet of newly renovated space. It entails the major renovation of an area currently occupied by an underutilized observation unit to establish 16 single-occupancy, anti-ligature, psychiatric-safe patient rooms and patient support areas. It will require the replacement of all plumbing, electrical and mechanical fixtures, finishes and furniture.

Projected capital costs of the proposed project total $14,201,216, of which $9,741,850 (68.6%) is direct construction cost (**Table 3**). Should the proposed project be approved, the entirety of capital costs, will be financed through accumulated reserves. The target date of opening is April 1, 2025.

Table 3. Capital and Financing Costs

Direct Construction Costs	$9,741,850
Equipment Not Included in Construction Contract	$2,556,600
Architectural & Engineering Fees	$962,550
Other Consultant Fees	$865,216
HUD-232 Financing	$75,000
Total Capital Costs	**$14,201,216**

Source: COPN Request No. VA-8697

Project Definition

§32.1-102.1:3 of the Code of Virginia defines a project, in part as, "An increase in the total number of beds or operating rooms in an existing medical care facility described in subsection A…." Medical care facilities are further defined, in part, as "Any facility licensed as a hospital as defined in § 32.1-123…" and "Introduction into an existing medical care facility described in subsection A any…psychiatric…service."

Required Considerations -- § 32.1-102.3, of the Code of Virginia

In determining whether a public need exists for a proposed project, the following factors shall be taken into account when applicable.

1. **The extent to which the proposed project will provide or increase access to health care services for people in the area to be served, and the effects that the proposed project will have on access to health care services in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to health care;**

On December 14, 2022, Governor Glenn Youngkin announced his three-year transformational behavioral health plan "Right Help, Right Now," acknowledging deficiencies in access to behavioral health services across the Commonwealth. Governor Youngkin stated, "We are facing

a behavioral health crisis across Virginia and the United States. This crisis is present throughout our society, at home, in schools and in the workplace."

Patients residing in rural areas of Virginia, such as PD 3, have further distances to drive for health care services, generally, than those in more urban areas. The availability of inpatient behavioral health resources is even scarcer for children and adolescents. There are only 14 private facilities across Virginia that have child/adolescent psychiatric beds and one state facility. There are none in PD 3 or in any adjoining PDs. The closest facility to JMH that offers child/adolescent psychiatric beds is over 120 miles at LewisGale Medical Center in Salem, Virginia. The applicant presents data from DBHDS indicating that 53% of child adolescent patients from PDs 1, 2 and 3 received care outside of Virginia. Of those that found a psychiatric bed within Virginia, 70% were placed more than 5 hours away.

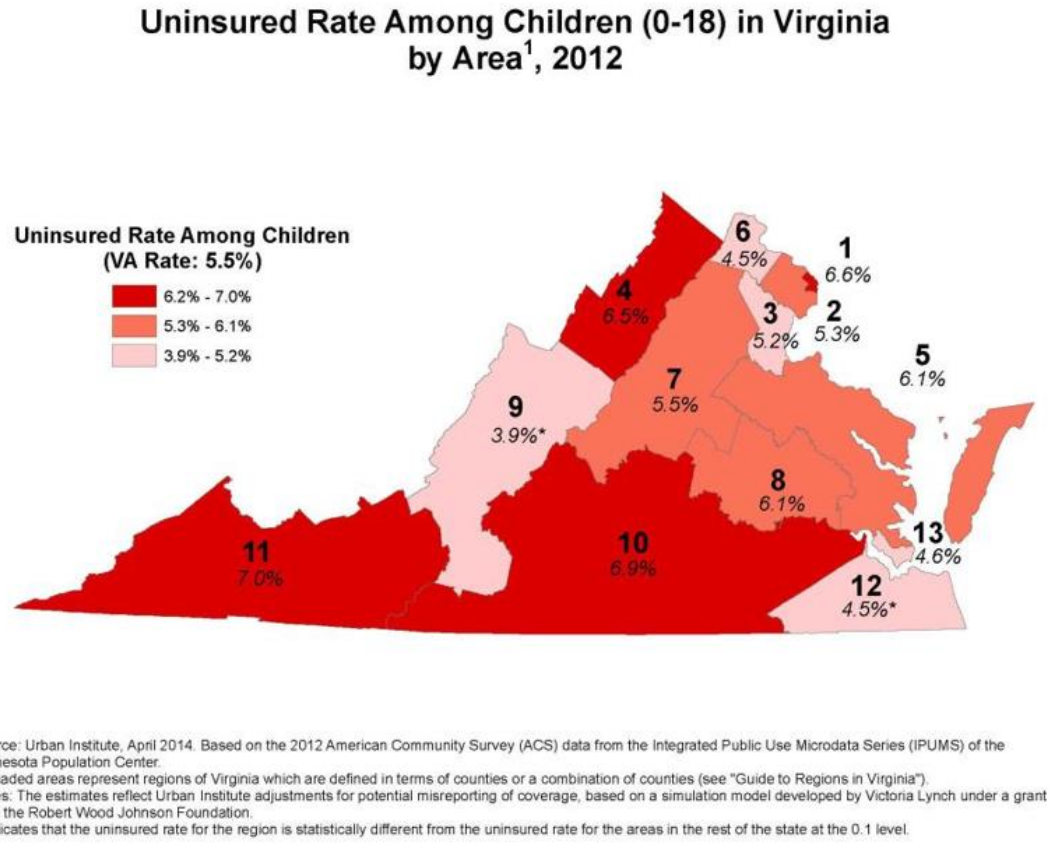
This distance is a significant barrier to access for children and adolescents in need of care, as long-distance travel is difficult for patients already struggling with mental health issues. According to letters of support from multiple area Community Services Boards (CSBs), patient outcomes are more positive with the support of family members, which support is not always possible when inpatient care is hours away. Patients and their families may be discouraged from seeking needed care knowing that resources are not available in their communities and traveling distances for patients and family members also creates financial burdens.

Regarding socioeconomic barriers to access, **Table 4** indicates that each of the counties in PD 3 has a higher poverty rate than that of Virginia as a whole. In addition, **Figure 4** shows that far southwest Virginia, where JMH is located, has the highest percentage of uninsured children of any other area in the Commonwealth.

Table 4. 2022 Poverty Rates, PD 3

Virginia	**10.2%**
Bland County	14.4%
Carroll County	14.0%
Galax City	21.9%
Grayson County	17.6%
Smyth County	17.5%
Washington County	13.3%
Wythe County	13.4%

Figure 4. Uninsured Rate Among Children



Source: Urban Institute, April 2014. Based on the 2012 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS) of the Minnesota Population Center.
1 Shaded areas represent regions of Virginia which are defined in terms of counties or a combination of counties (see "Guide to Regions in Virginia").
Notes: The estimates reflect Urban Institute adjustments for potential misreporting of coverage, based on a simulation model developed by Victoria Lynch under a grant from the Robert Wood Johnson Foundation.
* indicates that the uninsured rate for the region is statistically different from the uninsured rate for the areas in the rest of the state at the 0.1 level.

According to statewide data regularly collected by VHI, for 2020, the most recent year for which data are available, the average percentage of charity care provided by HPR III facilities was 0.7% of all reported total gross patient revenues (**Table 5**). JMH provided charity care at a slightly higher percentage of its gross patient revenue (0.91%). Pursuant to Section 32.1 – 102.4 of the Code of Virginia, should the Commissioner approve the proposed project, JMH would be subject to a charity care condition no less than the 0.7% HPR III average, in addition to any new requirements as found in the revised § 32.1-102.4B of the Code of Virginia.

Table 5. HPR III Charity Care Contributions

Health Planning Region III			
2020 Charity Care Contributions at or below 200% of Federal Poverty Level			
Hospital	**Gross Patient Revenues**	**Adjusted Charity Care Contribution**	**Percent of Gross Patient Revenue:**
Carilion Franklin Memorial Hospital	$146,159,934	$3,708,842	2.54%
Bedford Memorial Hospital	$122,377,242	$2,357,210	1.93%
Dickenson Community Hospital	$25,321,849	$465,722	1.84%
Carilion Tazewell Community Hospital	$57,945,546	$956,508	1.65%
Carilion Giles Memorial Hospital	$107,478,905	$1,438,902	1.34%
Russell County Medical Center	$121,070,842	$1,529,332	1.26%
Wellmont Lonesome Pine Mt. View Hospital	$372,115,538	$4,558,248	1.22%
Carilion Medical Center	$3,983,507,417	$47,514,964	1.19%
Carilion New River Valley Medical Center	$711,175,865	$8,034,717	1.13%
Johnston Memorial Hospital	$855,313,389	$7,815,178	0.91%
Norton Community Hospital	$311,397,944	$2,789,910	0.90%
Smyth County Community Hospital	$198,825,769	$1,746,804	0.88%
Centra Health	$2,649,888,465	$20,969,883	0.79%
LewisGale Hospital -- Montgomery	$680,834,380	$5,052,836	0.74%
Lewis-Gale Medical Center	$2,312,565,268	$16,202,296	0.70%
LewisGale Hospital -- Pulaski	$346,826,376	$2,140,319	0.62%
LewisGale Hospital -- Alleghany	$189,090,272	$708,265	0.37%
Twin County Regional Hospital	$222,632,986	$649,064	0.29%
Clinch Valley Medical Center	$520,600,957	$946,557	0.18%
Buchanan General Hospital	$99,508,254	$105,669	0.11%
Memorial Hospital of Martinsville & Henry County	$668,028,626	$582,956	0.09%
Wythe County Community Hospital	$235,991,599	$93,569	0.04%
Danville Regional Medical Center	$910,930,415	-$19,407,300	-2.13%
Total Facilities Reporting			23
Median			0.9%
Total $ & Mean %	**$15,849,587,838**	**$110,960,451**	**0.7%**

2. The extent to which the proposed project will meet the needs of people in the area to be served, as demonstrated by each of the following:

(i) the level of community support for the proposed project demonstrated by people, businesses, and governmental leaders representing the area to be served;

DCOPN received 18 letters of support for the proposed project from multiple CSBs in PDs 1, 2 and 3, as well as other area mental health providers; the Virginia Senator and Delegate representing the district; law enforcement agencies; the mayors of Abingdon and Marion; the president of Virginia Highlands Community College as well as its interim Dean of Health Programs; the Office of Community and Economic Development for the town of Marion; the Washington County Chamber of Commerce; and the director of behavioral medicine for JMH's Family Medicine Residency Program.

Collectively, these letters of support expressed the following:

- There is an ongoing and increasing need for additional health resources in the area, especially behavioral health and psychiatric services.

- Though there is a dire need across the Commonwealth, in far southwest Virginia "the need has reached a "distressingly critical and dangerous point."
- JMH makes invaluable contributions in the area and "has the expertise and commitment to the region and will fulfill this critical need."
- There are no providers of inpatient child/adolescent psychiatric services in PD 3.
- The only state child hospital is Commonwealth Center in Staunton, Virginia. It has had reduced capacity for over a year.
- The eight-bed Critical Stabilization Unit in Southwest Virginia (Mount Rogers) is expanding but does not offer inpatient services. It has offered to provide step down care from inpatient care, should the proposed project be approved.
- CSBs are "seldom able to find an available inpatient bed for a child/adolescent."
- Limited resources in the area result in financial and geographic barriers that delay access to critically important services.
- Children needing inpatient psychiatric care are at risk for self-injurious behavior or behavior that will harm others.
- Multiple examples were provided of children spending days in local emergency rooms awaiting care, less than ideal care for children and creating congestion and barriers to care for other emergency patients.
- When an inpatient bed is secured, it is at least three hours away.
- Appropriately involving familiar supports allows the reduction in overall trauma often experienced by youth needing inpatient psychiatric care. This contributes to better recovery outcomes. Having treatment closer to their home communities allows youth access to family visits and therapeutic interventions.
- Education providers expressed support for broader educational partnerships and expressed that the new treatment environment would also be a "rich new training environment" for future physicians and caregivers.
- JMH's proposed project would greatly enhance access and quality of care to individuals seeking inpatient treatment.

Public Hearing

Section 32.1-102.6 B of the Code of Virginia directs DCOPN to hold one public hearing on each application in a location in the county or city in which the project is proposed or a contiguous county or city in the case of competing applications; or in response to a written request by an elected local government representative, a member of the General Assembly, the Commissioner, the applicant, or a member of the public. COPN Request No. VA-8697 is not competing with another project in this batch cycle and DCOPN did not receive a request to conduct a public hearing for the proposed project. Thus, no public hearing was held.

(ii) the availability of reasonable alternatives to the proposed project that would meet the needs of the people in the area to be served in a less costly, more efficient, or more effective manner;

Because there is currently no provider of inpatient child/adolescent psychiatric services in PD 3 or surrounding PDs, there is no alternative to the establishment of inpatient child/adolescent psychiatric services that provides needed access to the people in the area served. Status quo is

untenable, requiring the continued transfer of children and adolescents out of state or two or more hours' drive time away from family/social support. No other project is identified to establish these services.

(iii) any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6;

Currently there is no organization in HPR III designated by the Virginia Department of Health to serve as the Health Planning Agency for PD 3. Therefore, this consideration is not applicable to the review of the proposed project.

(iv) any costs and benefits of the proposed project;

As demonstrated by **Table 3**, the projected capital costs of the proposed project total $14,201,216, of which $9,741,850 (68.6%) is direct construction. The entirety of the capital costs will be funded using the accumulated reserves of the applicant's parent company, Ballad Health. Accordingly, there are no financing costs associated with this project. DCOPN concludes that when compared to similar projects, these costs are reasonable. For example, COPN No. VA-04794 issued to The Pavilion to add 32 beds was approved at $1,619 per square foot, compared to $1,216 per square foot for the proposed 16-bed unit at JMH.

The applicant identified numerous benefits of the proposed project, including:

- The proposed project would establish and provide access to the only inpatient psychiatric service for children and adolescents within two hours from PD3, including those under TDOs.
- This service would address the financial and geographic barriers to access for patients and families currently seeking care hours outside the area and allow for familial support while children undergo inpatient services.
- The presence of an inpatient child and adolescent psychiatric facility would alleviate the strain on area emergency rooms and hospitals.
- Currently law enforcement resources provide supervision for children and adolescents awaiting placement to psychiatric services, and often transport to those services. By creating local access to these services, law enforcement would have more ability to accomplish their intended services to the community.

(v) the financial accessibility of the proposed project to the people in the area to be served, including indigent people; and

JMH plans to accept all forms of payment for services including commercial payors, government payors and private pay. Additionally, JMH intends to deliver charity care for patients that are unable to pay at a level equal to 0.7% of patient revenue. **Table 5** indicates that JMH offered charity care in 2020 at a rate higher than the HPR average. Under the state Local Inpatient Purchase of Services (LIPOS), the state disperses funds to CSBs for the purpose of securing inpatient psychiatric services for uninsured individuals when no state inpatient facility is

available. The applicant has stated it is prepared to accept child and adolescent patients under TDOs and multiple area CSBs have provided letters of support for the proposed project. The expected payor mix presented with the applicant's proforma includes 72% Medicaid, 3.3% Self Pay as well as 0.7% Charity.

Pursuant to Section 32.1 – 102.4 of the Code of Virginia, should the Commissioner approve the proposed project, JMH should be subject to a charity care condition no less than the 0.7% HPR III average, in addition to any new requirements as found in the revised § 32.1-102.4B of the Code of Virginia.

(vi) at the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a proposed project;

The six pillars of Governor Youngkin's "Right Help, Right Now" are:

1. Strive to ensure same-day care for individuals experiencing behavioral health crises.
2. Relieve the law enforcement community's burden and reduce the criminalization of mental health.
3. Develop more capacity throughout the system, going beyond hospitals, especially community-based services.
4. Provide targeted support for substance use disorder and efforts to prevent overdose.
5. Make the behavioral health workforce a priority, particularly in underserved communities.
6. Identify service innovations and best practices in pre-crisis prevention services, crisis care, post-crisis recovery and support and develop tangible and achievable means to close capacity gaps.

DCOPN reached out to the DBHDS for their input, but DBHDS did not provide feedback regarding the proposed project. DCOPN did not identify any other factors, not discussed elsewhere in this staff analysis report, to bring to the Commissioner's attention regarding the determination of a public need for the proposed project.

3. The extent to which the application is consistent with the State Medical Facilities Plan;

Section 32.1-102.2:1 of the Code of Virginia calls for the State Health Services Plan Task Force to develop recommendations for a comprehensive State Health Services Plan (SHSP). In the interim, DCOPN will consider the consistency of the proposed project with the predecessor of the SHSP, the State Medical Facilities Plan (SMFP).

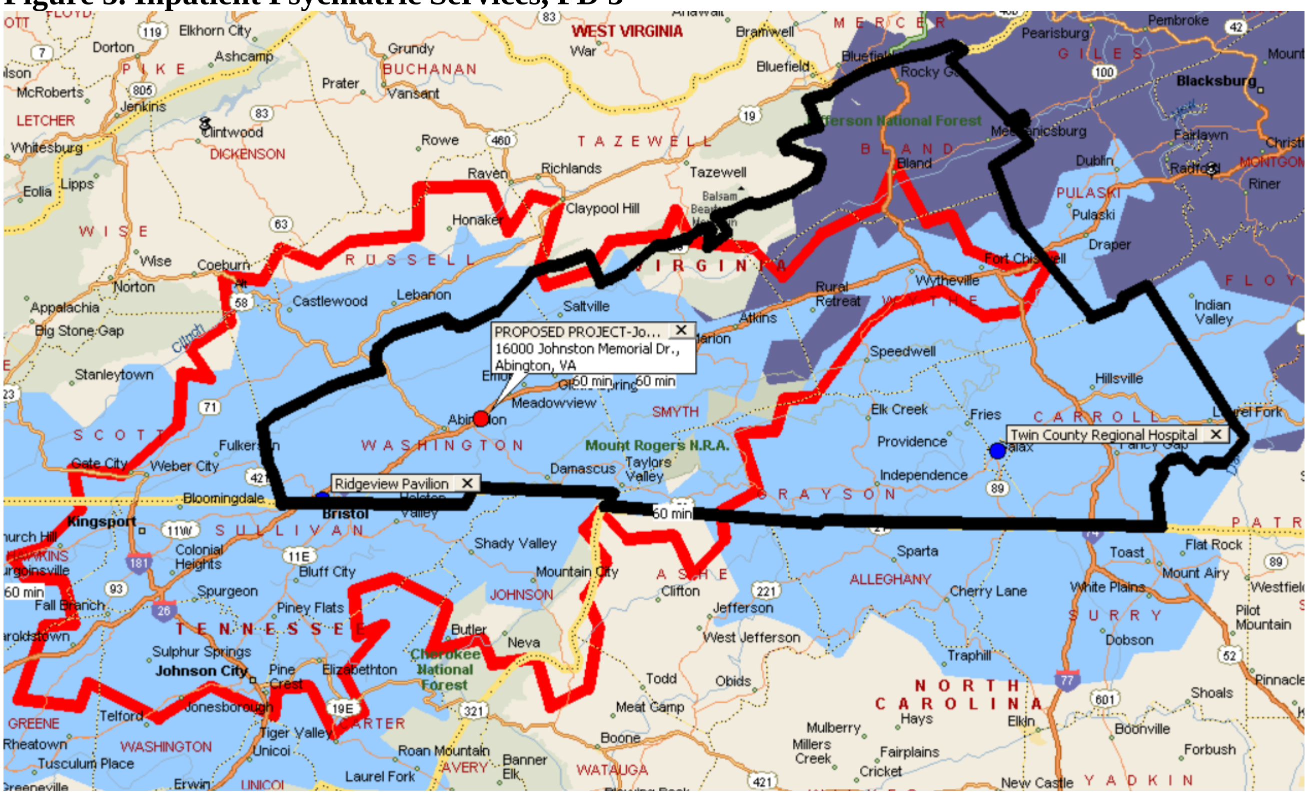
The State Medical Facilities Plan (SMFP) contains the criteria and standards for the addition of nursing beds. They are as follows:

Part XII. Mental Health Services
Article 1. Acute Psychiatric and Acute Substance Abuse Disorder Treatment Services

12VAC5-230-840. Travel Time.
Acute psychiatric and acute substance abuse disorder treatment services should be available within 60 minutes driving time one way under normal conditions of 95% of the population using mapping software as determined by the commissioner.

The blue shaded areas in **Figure 5** illustrate 60-minute driving times around the two existing (adult) acute psychiatric treatment facilities in PD 3. The purple shaded area represents additional coverage within 60-minutes of (adult) acute psychiatric facilities located outside of PD 3. The area encircled in red is 60 minutes from the proposed project and does increase geographic coverage within 60 minutes for other areas within PD 3, such that only a small area of Smyth County around Chatham Hill does not meet the 60-minute drive time standard.

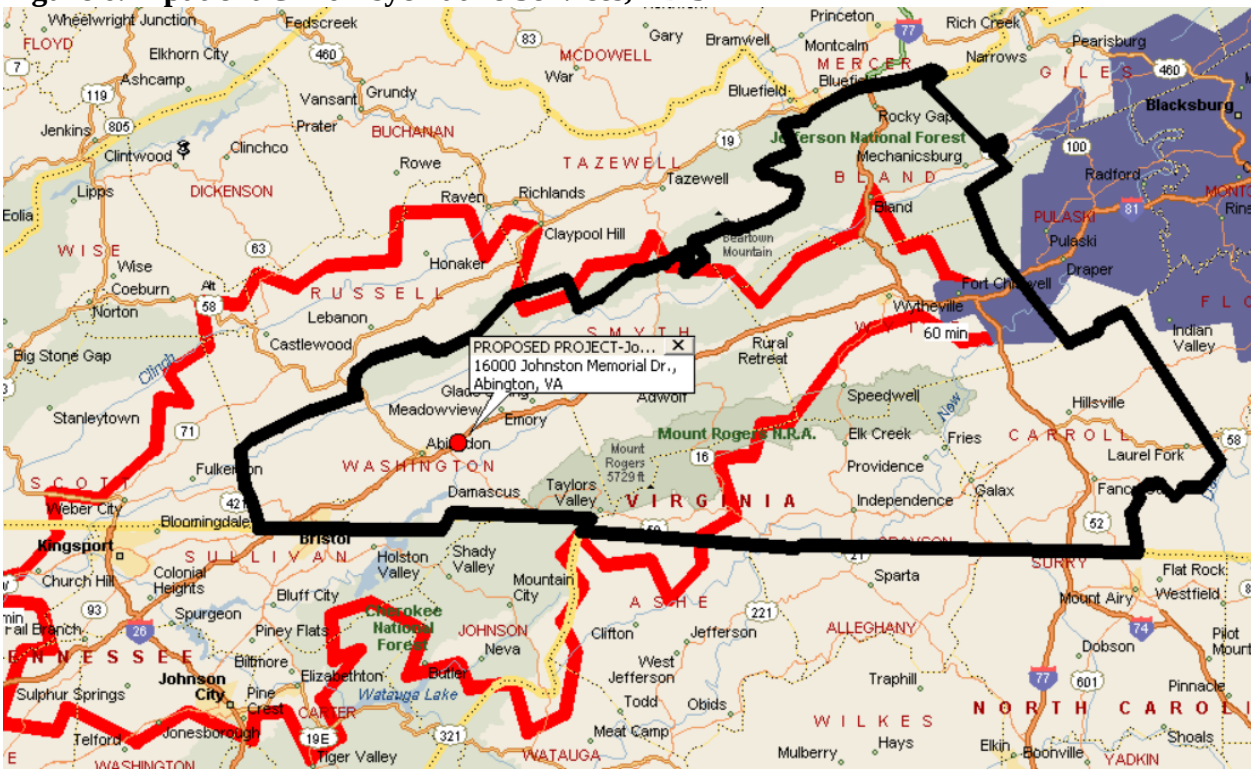
Figure 5. Inpatient Psychiatric Services, PD 3



Chatham Hill has not been included in census data, presumably because it does not have a population above the 5,000-person threshold (which would be approximately 3% of the population of PD 3) to be included in the census. It is likely that if existing providers don't currently provide coverage that meets the drive time goal, the addition of the proposed project would achieve it.

Though the SMFP does not make a distinction for child and adolescent services, the proposed project is specific to that segment of the population, and the 60-minute drive time standard is not achieved for children and adolescents in PD 3. **Figure 6** shows that there are no existing facilities in PD 3 that offer acute psychiatric services for children and adolescents. The purple shaded area shows the very small area of PD 3 that is within 60 minutes of child/adolescent psychiatric services outside PD 3. The area encircled in red shows a 60-minute drive time from JMH and illustrates that the proposed project would greatly expand geographic coverage for children and adolescents in PD 3.

Figure 6. Inpatient Child Psychiatric Services, PD 3



12VAC5-230-850. Continuity; Integration.

A. Existing and proposed acute psychiatric and acute substance abuse disorder treatment providers shall have established plans for the provision of services to indigent patients that include:

1. The minimum number of unreimbursed patient days to be provided to indigent patients who are not Medicaid recipients;

2. The minimum number of Medicaid-reimbursed patient days to be provided, unless the existing or proposed facility is ineligible for Medicaid participation;

3. The minimum number of unreimbursed patient days to be provided to local community services boards; and

4. A description of the methods to be utilized in implementing the indigent patient service plan and assuring the provision of the projected levels of unreimbursed and Medicaid-reimbursed patient days.

While there are no minimum days specified by the applicant, JMH projects that 72% of patients of the proposed project would be patients insured by Medicaid. As noted above, should the Commissioner approve the proposed project, JMH should be subject to a charity care condition no less than the 0.7% HPR III average, in addition to any new requirements as found in the revised § 32.1-102.4B of the Code of Virginia.

The applicant asserts that policies will be in place to address indigent and charity care and, when individuals are not otherwise eligible for assistance from government programs, the policy would provide how and when care can be provided.

DCOPN notes that few existing psychiatric facilities meet the criteria and standards set forth in 12VAC5-230-850. While some facilities may allocate a specific number of beds for CSB patients, the identification of the number of unreimbursed patient days to be provided to indigent patients who are not Medicaid recipients, the minimum number of Medicaid-reimbursed days, the minimum number of unreimbursed patient days to be provided to local CSBs, and a description of the methods to be utilized in implementing the indigent patient service plan, have not been addressed by DCOPN in recent reviews.

B. Proposed acute psychiatric and acute substance abuse disorder treatment providers shall have formal agreements with the appropriate local community services boards or behavioral health authority that:

1. Specify the number of patient days that will be provided to the community service board;

2. Describe the mechanisms to monitor compliance with charity care provisions;

3. Provide for effective discharge planning for all patients, including return to the patient's place of origin or home state if not Virginia; and

4. Consider admission priorities based on relative medical necessity.

The applicant asserts that it has had extensive conversations with the local CSBs and will formalize relationships, should the proposed project be approved, closer to the opening date. JMH anticipates collaborating with CSBs in the continuum of care for patients, expecting referrals from them and providing case management to encourage timely follow-up after discharge. JMH plans to audit access to appointments and monitor recidivism rates.

C. Providers of acute psychiatric and acute substance abuse disorder treatment serving large geographic areas should establish satellite outpatient facilities to improve patient access where appropriate and feasible.

The applicant is not proposing to establish a satellite outpatient facility, but states that it will work with the existing statewide network of CSBs and private providers to ensure patient access to outpatient care.

12VAC5-230-860. Need for New Service.
A. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a health planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both will be determined as follows:

((UR x PROPOP)/365)/.75

Where:

UR = the use rate of the health planning district expressed as the average acute psychiatric and acute substance abuse disorder treatment patient days per population reported for the most recent five-year period; and

PROPOP = the projected population of the health planning district five years from the current year as reported in the most recent published projections by a demographic entity as determined by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

For purposes of this methodology, no beds shall be included in the inventory of psychiatric or substance abuse disorder beds when these beds (i) are in facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services; (ii) have been converted to other uses; (iii) have been vacant for six months or more; or (iv) are not currently staffed and cannot be staffed for acute psychiatric or substance abuse disorder patient admissions within 24 hours.

UR = Patient Days from 2017 to 2021 / Population from 2017 to 2021

From **Table 6**:

UR = 33,871/ 936,180 = 0.03618
((UR x ProPop)/365)/.75 = ((0.03618 x 183,404)/365)/.75 = 24.2
Psychiatric Bed Need in PD 3 = 25 Beds
Staffed Beds, PD 3 (in 2021) = 32

Calculated Surplus of 7 Psychiatric Beds in PD 3

Table 6. PD 3 Psychiatric Beds, Patient Days and Population

Year	Licensed Beds	Staffed Beds	Patient Days	Population All Ages
2017	42	35	5,302	188,388
2018	42	35	7,165	187,797
2019	42	34	7,579	187,245
2020	48	32	6,286	186,608
2021	48	32	7,539	186,142
Total			**33,871**	**936,180**
Projected 2028				183,404

Source: VHI and Weldon Cooper

B. Subject to the provisions of 12VAC5-230-70, no additional acute psychiatric or acute substance abuse disorder treatment beds should be authorized for a health planning district with existing acute psychiatric or acute substance abuse disorder treatment beds or both if the existing inventory of such beds is greater than the need identified using the above methodology.

Preference may also be given to the addition of acute psychiatric or acute substance abuse beds dedicated for the treatment of geriatric patients in health planning districts with an excess supply of beds when such additions are justified on the basis of the specialized treatment needs of geriatric patients.

There is a calculated surplus of seven psychiatric beds in PD 3; however, in this case, the prescribed SMFP calculation is unlikely to reflect the true volume of patients that need psychiatric beds. For example, the proposed project is for children and adolescents and because there are no child/adolescent psychiatric beds in PD 3, none of the patient days associated with PD 3 children and adolescents are included in the utilization rate in the SMFP bed need calculation. In addition, many patients under TDOs are referred to overcrowded state institutions and are not included in the utilization rate.

C. No existing acute psychiatric or acute substance disorder abuse treatment beds should be relocated unless it can be reasonably projected that the relocation will not have a negative impact on the ability of existing acute psychiatric or substance abuse disorder treatment providers or both to continue to provide historic levels of service to Medicaid or other indigent patients.

Not applicable. The applicant is not proposing to relocate existing acute psychiatric or acute substance disorder abuse treatment beds.

D. The combined number of acute psychiatric and acute substance abuse disorder treatment beds needed in a health planning district without existing acute psychiatric or acute substance abuse disorder treatment beds will be determined as follows:

((UR x PROPOP)/365)/.75

Where:

UR = the use rate of the health planning region in which the health planning district is located expressed as the average acute psychiatric and acute substance abuse disorder treatment patient days per population reported for the most recent five-year period;

PROPOP = the projected population of the health planning district five years from the current year as reported in the most recent published projections by a demographic entity as determined by the Commissioner of the Department of Mental Health, Mental Retardation and Substance Abuse Services.

There are existing acute psychiatric beds in PD 3 but there are no child/adolescent psychiatric beds in PD 3 nor in surrounding PDs. Though 12VAC5-230-860 makes no distinction for child/adolescent psychiatric beds, it is the segment of the population that the proposed project would serve. It is reasonable to modify the prescribed calculation to estimate need for psychiatric beds in PD3 specific to the child/adolescent population segment.

In the absence of child/adolescent psychiatric beds/patient days in PD 3, the need for child/adolescent psychiatric beds in PD 3 is calculated as follows, using the HPR III child/adolescent use rate:

$$UR = \frac{\text{Child/Adolescent Psychiatric Patient Days from 2017 to 2021 (HPR III)}}{\text{Population age 6 to 17 from 2017 to 2021 (HPR III)}}$$

From **Table 7**:

UR = 63,278 / 879,761 = 0.072

((UR x ProPop PD 3 age 6 to 17)/365)/.75 = ((0.072 x 117,779)/365)/.75 = 31

Child/Adolescent Psychiatric Bed Need in PD 3 = 31 Beds
Staffed Child/Adolescent Psychiatric Beds, PD 3 (in 2021) = 0

Calculated Shortage in PD 3 = 31 Child/Adolescent Psychiatric Beds

Table 7. PD 3 Child/Adolescent Bed Need (HPR III Use Rate)

Year	C/A Psych Beds in PD3	C/A Psych Patient Days, HPR III	HPR III Population Ages 6 to 17
2017	0	11,740	177,558
2018	0	11790	176,738
2019	0	14097	175,922
2020	0	12,719	174,908
2021	0	12932	174,634
Total	**0**	**63,278**	**879,761**
Projected 2028 PD 3 Population, Age 6 to 17			117,779

Source: VHI, Weldon Cooper and DCOPN extrapolations

E. Preference may be given to the development of needed acute psychiatric beds through the conversion of unused general hospital beds. Preference will also be given to proposals for acute psychiatric and substance abuse beds demonstrating a willingness to accept persons under temporary detention orders (TDO) and that have contractual agreements to serve populations served by community services boards, whether through conversion of underutilized general hospital beds or development of new beds.

The proposed project is not competing with another project and is not proposing the conversion of general hospital beds. JMH has expressed a willingness to accept children/adolescents under TDOs, should the proposed project be approved.

12VAC5-230-80. When Institutional Expansion is Needed.

1. **Notwithstanding any other provisions of this chapter, the commissioner may grant approval for the expansion of services at an existing medical facility in a health planning district with an excess supply of such services when the proposed expansion can be justified on the basis of a facility's need having exceeded its current service capacity to provide such service or on the geographic remoteness of the facility.**
2. **If a facility with an institutional need to expand is part of a health system, the underutilized services at other facilities within the health system should be reallocated, when appropriate, to the facility with the institutional need to expand before additional services are approved for the applicant. However, underutilized services located at a health system's geographically remote facility may be disregarded when determining institutional need for the proposed project.**
3. **This section is not applicable to nursing facilities pursuant to §32.1-102.3:2 of the Code of Virginia.**
4. **Applicants shall not use this section to justify a need to establish new services.**

Not applicable. The proposed project is a new service and not arguing an institution-specific need.

Required Considerations Continued

4. The extent to which the proposed project fosters institutional competition that benefits the area to be served while improving access to essential health care services for all people in the area to be served;

The proposed project does not foster institutional competition. There are no other providers of inpatient child/adolescent psychiatric services in PD 3.

5. The relationship of the proposed project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities;

JMH is one of four acute care hospitals in rural PD 3. The others are Smyth County Community Hospital, Wythe County Community Hospital and Twin County Regional Hospital. There is also a rehabilitation hospital in Bristol, Virginia as well as Ridgeview Pavilion, a psychiatric facility without child/adolescent beds in Bristol, Virginia, also a Ballad Health facility.

JMH serves as the hub for Ballad Health's sub-system model between JMH, Russell County Medical Center, and Smyth County Community Hospital. JMH is also a member of the Ballad Health Niswonger Children's Network, linking it to pediatric care in the region. The proposed project will provide access to behavioral health services and a referral pathway for other providers in the Niswonger Children's Network.

6. The feasibility of the proposed project, including the financial benefits of the proposed project to the applicant, the cost of construction, the availability of financial and human resources, and the cost of capital;

The proposed project has an expected capital cost of $14,201,216 which would be funded through accumulated reserves of Ballad Health, if approved. There would, therefore, be no financing costs associated with the proposed project. The proforma (**Table 8**) projects a loss in the first and second years of operation. JMH anticipates that the child and adolescent psychiatric beds will operate at a loss ongoing and is prepared to subsidize the service with revenues from other service lines in order to ensure access. Some financial benefits are expected (but difficult to quantify) as access to psychiatric services will reduce time and disruption in the emergency room and decrease recidivism,

Table 8. JMH Child/Adolescent Psychiatric Bed Pro Forma Income Statement

	Year 1	Year 2
Total Gross Patient Revenue	**$1,012,955**	**$4,408,382**
Contractual Allowances	$405,182	$1,763,353
Charity Care	$7,091	$30,859
Net Operating Revenue	**$600,682**	**$2,614,170**
Total Operating Expenses	**$649,511**	**$2,826,671**
Depreciation	$3,111	$13,538
Pre-Tax Income	**-$51,940**	**-$226,039**

Source: COPN Request No. VA-8697

The applicant's staffing documentation shows that the proposed project will require 30.3 additional full-time equivalent (FTE) employees and that JMH currently has 88.8 FTE vacancies. In addition to job fairs and other recruiting events, JMH states that Ballad Health has existing relationships with local colleges and universities, including some medical schools. The recruitment plan for the proposed project includes the recruitment of psychiatrists, psychiatric advanced practice providers and nursing and therapy staff from the pool of new candidates entering these fields through these established relationships. Ballad is partnering with East Tennessee State University (ETSU) to add a child/adolescent residency fellowship program to its psychiatry residency programs. JMH states that the project is not anticipated to have any significant negative impact on the staffing of other area facilities, and many of the stated recruitment efforts target providers directly from training programs. One of the pillars of Governor Youngkin's plan for behavioral health is to make the behavioral health workforce a priority, particularly in underserved communities. Given current staffing challenges across Virginia, DCOPN would expect such an emphasis may be of benefit to the proposed project.

7. **The extent to which the proposed project provides improvements or innovations in the financing and delivery of health care services, as demonstrated by; (i) the introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services; (ii) the potential for provision of health care services on an outpatient basis; (iii) any cooperative efforts to meet regional health care needs; and (iv) at the discretion of the Commissioner, any other factors as may be appropriate; and**

The proposed project will not introduce new technology that would promote quality or cost effectiveness in the delivery of inpatient health services or increase the potential for the provision of health care services on an outpatient basis. The proposed project received support from several local CSBs and the applicant has expressed its intention to accept patients under TDOs. DCOPN did not identify any other factors, not discussed elsewhere in this staff analysis report, to bring to the Commissioner's attention regarding the determination of a public need for the proposed project.

8. **In the case of a project proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be served, (i) the unique research, training, and clinical mission of the teaching hospital or medical school, and (ii) any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care for citizens of the Commonwealth, including indigent or underserved populations.**

According to the director of behavioral medicine for JMH's family medicine residency program, the proposed project would benefit the educational experience of family medicine residents. In addition, the applicant has an affiliation agreement with the Edward Via College of Osteopathic Medicine in Blacksburg, Virginia. Medical students complete core clerkships at JMH each year and the applicant states that the proposed project will enhance the educational mission of JMH for residents and medical students. Psychiatry is a required clerkship during the third and fourth years of medical education. As ETSU's child/adolescent residency fellowship program is added to its psychiatry residency programs, residents of that program would also benefit from the proposed project.

DCOPN Staff Findings and Conclusions

The proposed project will increase needed access to care for children and adolescents in PD 3 and surrounding PDs, alleviating geographic and socioeconomic barriers for residents of rural Southwest Virginia. The proposed project will be financially accessible to area children and adolescents. There is no alternative to the proposed project, and it is superior to the status quo, providing local inpatient psychiatric services for children and adolescents in PD 3 and the surrounding PDs. Proposed costs are reasonable and there are significant benefits to the proposed project. There is widespread and strong community support for the proposed project, and it aligns with Governor Youngkin's behavioral health initiatives.

DCOPN finds the proposed project generally consistent with the applicable criteria and standards of the SMFP and the Eight Required Considerations of the Code of Virginia. While there is a calculated surplus of psychiatric beds in PD 3 generally, the proposed project is specific to inpatient child/adolescent psychiatric services, and there is an estimated bed need for the child/adolescent segment of the population. There are no child/adolescent psychiatric beds in PD 3 and furthermore, none of the existing child/adolescent psychiatric beds in the Commonwealth are west of Salem, Virginia. The proposed project would serve to address a shortage and maldistribution of inpatient psychiatric services for children and adolescents in PD 3 and other portions of Southwest Virginia.

The proposed project is expected to operate at a loss, but JMH and Ballad Health are prepared to subsidize it in order to offer needed child/adolescent psychiatric services in the area. JMH and Ballad Health are financially capable of such a subsidization. As health care staffing is challenging across the state, Governor Youngkin's intention to focus on the behavioral health workforce is timely to the proposed project.

Due to Ballad Health's affiliations, the proposed project is likely to further the educational missions of area medical schools and training programs.

Staff Recommendation

DCOPN recommends **conditional approval** of JMH's request to introduce child/adolescent psychiatric services with 16 inpatient beds restricted to the provision of child/adolescent psychiatric services for the following reasons:

1. The proposed project supports Governor Youngkin's behavioral health initiative.

2. The proposed project is consistent with the applicable criteria and standards of the State Medical Facilities Plan and the Eight Required Considerations of the Code of Virginia.

3. The proposed project is more advantageous than the status quo.

4. The capital costs of the proposed project are reasonable.

5. The proposed project has strong community support and is supported by local community services boards.

6. DCOPN did not receive any opposition to the proposed project.

7. The applicant has committed to accepting patients presenting under temporary detention orders.

DCOPN's recommendation is contingent upon JMH's agreement to the following charity care condition:

JMH will provide child and adolescent inpatient psychiatric services to all persons in need of these services, regardless of their ability to pay, and will provide as charity care to all indigent persons free services or rate reductions in services and will facilitate the development and operation of primary medical care services to medically underserved persons in PD 3 in an aggregate amount equal to at least 0.7% of JMH's gross patient revenue derived from inpatient psychiatric services. Compliance with this condition will be documented to the Division of Certificate of Public Need annually by providing audited or otherwise appropriately certified financial statements documenting compliance with the preceding requirement. JMH will accept a revised percentage based on the regional average after such time regional charity care data valued under the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. is available from Virginia Health Information. The value of charity care provided individuals pursuant to this condition shall be based on the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.

JMH will provide inpatient psychiatric care to individuals who are eligible for benefits under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.), Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), and 10 U.S.C. § 1071 et seq. JMH will facilitate the development and operation of primary and specialty medical care services in designated medically underserved areas of the applicant's service area.